

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST CHRYSTAL, TN 37167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The Annual Recertification Survey, and Complaint Investigations numbers TN28824, TN29253, TN28990, TN28886, TN29748, TN28697, and TN29281, were conducted August 12 to 14, 2012. No deficiencies were cited related to the complaints under 42 CFR Part 482.13, Requirements for Long Term Care. F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and review of facility documentation, the facility failed to ensure the placement of safety devices for two (#6, #13) of twenty-two residents reviewed. The findings included: Resident #6 was admitted to the facility on May 18, 2012, with diagnoses including Bilateral Amputee, Senile Dementia, Acute Venous Embolism, Diabetes Mellitus, Senile Organic Psychotic Condition and Neurotic Disorders.	F 000	<u>Disclaimer for Plan of Correction</u> Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Rutherford County of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Rutherford County files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings. F 323 Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	<p>Continued From page 1</p> <p>Medical record review of a significant change Minimum Data Set dated August 7, 2012, revealed the resident as severely cognitively impaired, and required extensive assistance with all activities of daily living.</p> <p>Medical record review of the resident's Care Plan, dated August 8, 2012, revealed, "... (resident) is at high risk for falls and/or injuries related to bilateral AKA (above knee amputation), cognitive deficit and requiring staff assistance for all transfers..."</p> <p>Observation of the resident on August 12, 2012, at 9:45 a.m., in the resident's room, revealed the resident in a Geri-chair, with the back of the chair reclined, the foot of the chair raised, and the wheels of the Geri-chair unlocked. Continued observation revealed the resident reached arms out, grabbed the bedside table which was located slightly to the left and in front of the resident, and was pulling the Geri-chair forward.</p> <p>Interview with Registered Nurse (RN) #1 on August 12, 2012 at 9:55 a.m., in the resident's room, confirmed the wheels of the Geri-chair were unlocked and the wheels of the Geri-chair were to be locked when the resident was in the chair.</p> <p>Observation of the resident on August 13, 2012, at 7:47 a.m., in the B Wing Dining Room, revealed the resident sitting in the Geri-chair pushed up to a table with breakfast tray in front of the resident. Continued observation revealed the back of the Geri-chair was in the forward position, foot of chair down, and a clip alarm box attached to the back of the chair. Further observation</p>	F 323	<p>standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Residents</u></p> <p>Wheels of Resident #6's Geri-chair were locked by staff on 8/13/12. The clip alarm for Resident #6 was re-attached by staff on 8/13/12.</p> <p>On 8/13/12, Resident #13's pressure pad alarm was connected to the alarm box.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Current residents utilizing safety devices and/or Geri-chairs were evaluated by the Director of Nursing and Assistant Director of Nursing on 8/24/12. Geri-chair wheels were locked, pressure pads and clip alarms were connected and attached appropriately.</p> <p><u>Systematic Changes</u></p> <p>In-service training was held on 8/13/12 by the Director of Nursing and Assistant Director of Nursing, and will be repeated 8/24/12 by the Director of Nursing regarding the need for Geri-</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(K3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167		
(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETION DATE	
F 323	<p>Continued From page 2</p> <p>revealed the wheels of the Geri-chair were not locked and the clip alarm was not attached to the resident.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on August 13, 2012, at 7:50 a.m., in the B Wing Dining Room, confirmed the clip alarm was not attached to the resident and the wheels of the Geri-chair were not locked.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on August 13, 2012, at 8:00 a.m., in the B Wing Dining Room, confirmed the wheels of the Geri-chair were to be locked while the resident was in the Geri-chair.</p> <p>Observation of the resident on August 13, 2012, at 8:45 a.m., in the Activity Room, revealed the resident in the Geri-chair, with the back of the chair reclined, the foot of the chair raised, and the wheels of the chair were not locked.</p> <p>Interview with the Director of Nursing (DON) on August 13, 2012, at 9:55 a.m., in the Activity Room, confirmed the wheels of the Geri-chair were to be locked when the resident is in the Geri-chair.</p> <p>Observation of the resident on August 13, 2012, at 12:56 p.m., in the resident's room, revealed the resident in the Geri-chair, with the back reclined, the foot of the chair raised, and the wheels not locked.</p> <p>Interview with CNA #2 on August 13, 2012, at 1:00 p.m., confirmed the wheels of the Geri-chair were not locked.</p>	F 323	<p>chair wheels being locked while residents are not being transported and to educate staff on the importance of residents' safety devices being in place and alarm boxes attached to sensor pads. Newly-hired employees will be educated regarding appropriate use and placement of safety devices during their orientation period.</p> <p><u>Monitoring</u></p> <p>The Charge Nurse for each unit will make rounds daily for three months to ensure that proper procedures for locking wheels of Geri-chairs and positional alarms are attached. Results of these audits will be reviewed and presented to the monthly Performance Improvement Committee by the Assistant Director of Nursing for three months for any further recommendations. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.</p>	9/15/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37187		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID - PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	<p>Continued From page 3</p> <p>Review of facility documentation, "In-Service Sign-In Sheet", dated August 13, 2012, revealed, "...Geri-chair brakes are to be locked when parked in dining room/hall or resident's room..."</p> <p>Resident #13 was admitted to the facility on April 16, 2012, with diagnoses including Dementia with Lewy Bodys, Paralysis Agitans, Muscle Weakness, and Hearing Loss.</p> <p>Medical record review of quarterly Minimum Data Set (MDS) dated July 24, 2012, revealed the resident was significantly cognitively impaired and required extensive assistance with all activities of daily living.</p> <p>Medical record review of the resident's Care Plan, dated April 24, 2012, revealed, "...[resident] is at risk for falls and or injuries related to having a h/o (history of) falls..."</p> <p>Medical record review of a Nursing Change in Condition form, dated April 28, 2012, revealed, "...[due to] resident being able to take pull tab off of shirt added pressure pad while in w/c (wheelchair)..."</p> <p>Observation of the resident on August 13, 2012, at 3:14 p.m., revealed the resident in a wheelchair sitting in the hallway of 100 Wing. Continued observation revealed a pressure pad alarm box on the back of the wheelchair without the cord from the pad alarm connected to the alarm box.</p> <p>Interview with CNA #2 on August 13, 2012, at 3:15 p.m., in the 100 Wing hallway confirmed the</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 4 pressure pad alarm was not connected to alarm box and would not alarm if the resident attempted to rise from the wheelchair.	F 323			
F 371 SS=F	483.36(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sanitary storage of food and equipment. The findings included: Observation of the dietary department on August 12, 2012, from 10:10 a.m. until 11:00 a.m., revealed: 1. One seven pound three ounce can of Pork and Beans was dented and was available for use; 2. One seven pound four ounce can of Blueberry Pie filling was dented and was available for use; 3. Two fifty ounce cans of Tomato Soup were dented and were available for use; 4. A stand up electric slicer had food debris on the lip, the blade, and the top of the machine, and was available for use;	F 371	F 371 Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Residents</u> Dented food cans were removed from stock and labeled "Do Not Use." The stand-up slicer, food processor, cited spatula, eleven-quart pot, two-quart pan, 4-inch pans, and the 1/3 sheet pans were cleaned and allowed to air dry completely before being returned to storage on 8/12/12 by the Dietary Manager. The measuring cup was removed from the plastic container of thickener. All opened food was placed in clean containers, labeled with the date, and closed completely prior to storage by the Dietary Manager on 8/12/12. The deep fat fryer and area around the fryer were cleaned and sanitized by the Dietary Manager on 8/12/12.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 5</p> <p>5. Food processor had food debris on top of the machine, in the bowl, and on the blade, and was available for use;</p> <p>6. A spatula in the clean storage section had food debris on it and greasy to touch, was available for use;</p> <p>7. A plastic container of Thickener was not labeled and had a measuring cup down inside the thickener, was available for use;</p> <p>8. A twenty-four count package of one ounce tea bags was completely open and stored in an uncovered plastic container with debris in it under a shelf in the kitchen, and was available for use;</p> <p>9. The floor in the dishwasher section of the main dietary department had free standing water on it without a Wet Floor Sign present;</p> <p>10. The two tray deep fryer had a heavy build up of grease around it with crumbs and food debris stuck in it;</p> <p>11. Two garbage cans in the kitchen with a step to open and close lid did not work. The lids were open at all times;</p> <p>12. Three sixteen quart pots were stored under a sink and below the drain pipe;</p> <p>13. An eleven quart pot hanging over the sink had dry crusted food stuck to the bottom and was available for use;</p> <p>14. A two quart pan was hanging over the sink wet and was available for use;</p> <p>15. Two of three 200-4 inch pans stored on the wire rack were wet and available for use;</p> <p>16. Three of five 1/3 sheet pans had food debris stuck to them, and two of five were wet, were on the shelf and available for use;</p> <p>17. A dietary worker placed clean silverware and straws in plastic bags for resident use without wearing gloves;</p> <p>18. The vent hood was dirty with splattered</p>	F 371	<p>Free-standing water was mopped up and Wet Floor sign was placed by the Dietary Manager on 8/12/12. The two cited garbage cans were replaced by the Dietary Manager on 8/13/12. The three sixteen-quart pots stored under the sink were removed by Dietary staff on 8/12/12 and stored above drain pipe. The vent hood was cleaned of debris and grease on 8/13/12 by the Dietary Manager.</p> <p>On 8/21/12, after receiving the Statement of Deficiencies, the Dietary staff was counseled by the Dietary Manager about wearing gloves when bagging utensils.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Current Residents in the facility have the potential to be affected by this practice. On 8/12/12, the Dietary Manager and Registered Dietician completed a walk-thru of the kitchen to ensure no other kitchen items/issues were out of compliance at that time.</p> <p><u>Systematic Changes</u></p> <p>In-service training for Dietary staff was conducted by the Dietary Manager on 8/27/12, and will be repeated again on 8/31/12, regarding removing dented cans from food stock; cleaning and allowing pots, pans, dishes and utensils</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
F 371	Continued From page 6 food and grease on it. Interview with the dietary manager on August 12, 2012, at 11:15 a.m., in the dietary department, confirmed dented cans were to be removed from stock, the spatula needed to clean and dried completely before being stored for use, all open food was to be labeled with the date and closed completely prior to storage, the stand up slicer and food processor were to be cleaned completely after each use before storage, there needed to be a Wet Floor Sign in the dishwasher area of the kitchen, the area around the deep fryer needed to be cleaned and sanitized, the two garbage cans needed to be repaired or replaced so the lids would close, all pots and pans were to be clean and dry prior to being returned to storage, and the vent hood needed to be cleaned.	F 371	to air dry completely before returning to storage; cleaning and sanitizing appliances and areas around appliances; no storage below the sink drain pipe or under shelves; replacing or repairing items, such as garbage cans, when in disrepair; wearing gloves when handling clean silverware, straws for resident use; storing opened food labeled with date, in clean containers with lid closed completely, and not storing measuring cup in food item containers; maintaining a clean vent hood; and placing a Wet Floor sign when free-standing water is present. The Dietary Manager, directed by the Registered Dietician, will conduct weekly audits for three months in		
F 372 SS=D	483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of garbage and refuse properly to maintain sanitary conditions. The findings included: Observation of the garbage and refuse dumpsters on August 12, 2012, from 11:00 a.m. until 11:15 a.m., revealed the garbage dumpster had one side sliding door completely open and a bag of garbage protruding from the door.	F 372	regard to kitchen sanitation and food storage. Audits will include compliance with Kitchen Cleaning Schedule; completely cleaning and drying dishes, silverware, utensils, and pots and pans before returning to storage; cleaning and sanitizing appliances and areas around appliances; discarding/repairing items in disrepair; wearing gloves when handling clean silverware; maintaining a clean vent hood; utilizing Wet Floor signs if free-standing water is present; storing food in clean containers, labeled with the date and lid completely closed; storing items above the sink drain pipe and shelves; and not storing measuring cups in food containers. Newly-hired		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 6 food and grease on it. Interview with the dietary manager on August 12, 2012, at 11:15 a.m., in the dietary department, confirmed dented cans were to be removed from stock, the spatula needed to clean and dried completely before being stored for use, all open food was to be labeled with the date and closed completely prior to storage, the stand up slicer and food processor were to be cleaned completely after each use before storage, there needed to be a Wet Floor Sign in the dishwasher area of the kitchen, the area around the deep fryer needed to be cleaned and sanitized, the two garbage cans needed to be repaired or replaced so the lids would close, all pots and pans were to be clean and dry prior to being returned to storage, and the vent hood needed to be cleaned.	F 371	Dietary staff will be educated on kitchen sanitation and food storage procedures during their orientation period. The Registered Dietician will also audit the kitchen bi-weekly for three months for sanitation and food storage compliance. The Registered Dietician will also observe kitchen staff for best practices at that time. <u>Monitoring</u> The Dietary Manager will present results of these audits to the monthly Performance Improvement Committee for three months for review and recommendations. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.	9/15/12	
F 372 SS=D	483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of garbage and refuse properly to maintain sanitary conditions. The findings included: Observation of the garbage and refuse dumpsters on August 12, 2012, from 11:00 a.m. until 11:15 a.m., revealed the garbage dumpster had one side sliding door completely open and a bag of garbage protruding from the door.	F 372	Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 371	Continued From page 8 food and grease on it. Interview with the dietary manager on August 12, 2012, at 11:15 a.m., in the dietary department, confirmed dented cans were to be removed from stock, the spatula needed to clean and dried completely before being stored for use, all open food was to be labeled with the date and closed completely prior to storage, the stand up slicer and food processor were to be cleaned completely after each use before storage, there needed to be a Wet Floor Sign in the dishwasher area of the kitchen, the area around the deep fryer needed to be cleaned and sanitized, the two garbage cans needed to be repaired or replaced so the lids would close, all pots and pans were to be clean and dry prior to being returned to storage, and the vent hood needed to be cleaned.	F 371	surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Residents</u> The dumpster door was closed on 8/12/12 by the Dietary Manager. <u>Identification of Other Residents with Potential to be Affected</u> Other dumpsters were checked by the Maintenance Director on 8/12/12 and found to be in compliance. <u>Systematic Changes</u> A general staff meeting was held on 8/24/12 and in-servicing was conducted by the Administrator on keeping dumpster doors closed at all times. Each department manager will continue to in-service staff, with completion on 8/31/12. <u>Monitoring</u> Dumpsters will be checked daily by the Maintenance Director and Dietary Manager, and on the weekends by the weekend supervisor for three months to ensure that dumpster doors are closed. Results of findings will be reported by the Maintenance Director to the monthly Performance Improvement Committee meeting for three months		
F 372 SS=D	483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of garbage and refuse properly to maintain sanitary conditions. The findings included: Observation of the garbage and refuse dumpsters on August 12, 2012, from 11:00 a.m. until 11:15 a.m., revealed the garbage dumpster had one side sliding door completely open and a bag of garbage protruding from the door.	F 372			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 446502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 372	Continued From page 7	F 372	for review and recommendations to ensure on-going compliance. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.	9/15/12	
F 441 SS=D	<p>Interview with the dietary manager on August 12, 2012, at 11:15 a.m., at the dumpsters, confirmed the doors of the dumpster were not closed and garbage was not contained.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>	F 441	<p>Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Residents</u></p> <p>The drainage system's bags and tubing for Resident #4 were repositioned by staff on 8/12/12 to prevent them from touching the floor.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST BMYRNA, TN 37167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 8</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and interviews, the facility failed to maintain proper positioning of a closed drainage systems, to prevent bacterial contamination, for one resident (#4) of twenty-two residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #4 was admitted to the facility on August 9, 2012, with diagnoses of: Diabetes Mellitus Type II, Hypertension, Peripheral Vascular Disease, Gastroesophageal Reflux Disease, Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease.</p> <p>Medical record review revealed the resident had an indwelling rectal tube (a tube inserted into the rectum to relieve gases and reduce soiling of wounds with feces) and a urinary catheter (a tube inserted in the bladder for urine), in place on admission.</p> <p>Observations of Resident #4, in the resident's room, on August 12, 2012, at 10:10 a.m., revealed the resident's urinary catheter tubing was lying on the floor, beside the bed, and the urine collection bag was touching the floor. Further observation revealed the tubing from the</p>	F 441	<p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Residents with closed drainage systems have a potential to be affected by this practice. Residents with these systems were checked by staff on 8/12/12 to ensure system bags and tubing had no contact with the floor.</p> <p><u>Systematic Changes</u></p> <p>In-service training was conducted on 8/13/12, 8/24/12, and 8/28/12 by the Director of Nursing to educate nursing staff on the importance of closed drainage system tubing and collection bags being positioned to avoid touching the floor. Newly-hired employees will be educated on appropriate positioning of closed drainage system bags and tubing during their orientation period.</p> <p><u>Monitoring</u></p> <p>An infection control observation audit will be completed daily by the Charge Nurse for each unit. This audit will be presented to the Assistant Director of Nursing/Director of Nursing daily at the end of each shift for two weeks, then weekly for two weeks, and monthly for two months. Results of the audit will be reviewed by the Director of Nursing with results reported to the monthly</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 9</p> <p>rectal tube to the feces collection bag was lying on the floor beside the bed, and the feces collection bag was touching the floor.</p> <p>Interview with the Director of Nurses (DON) on August 12, 2012, at 10:20 a.m., in Resident #4's room, confirmed the urinary catheter tubing was lying on the floor, and the urine collection bag was touching the floor. Further interview with the DON confirmed the rectal tubing was lying on the floor, and the feces collection bag was touching the floor. The DON confirmed the bags and tubing were to be kept off the floor.</p> <p>Observations of Resident #4, in the resident's room, on August 13, 2012, at 7:25 a.m., revealed the tubing from the urinary catheter lying in the floor, beside the resident's bed, and the urine collection bag touching the floor. Further observations revealed the rectal tubing lying in the floor, beside the bed, and the fecal collection bag touching the floor.</p> <p>Interview with the Assistant Director of Nursing (ADON), in Resident #4's room, on August 13, 2012, at 7:28 a.m., confirmed the tubing and collection bags were touching the floor. Further interview with the ADON confirmed the tubing and collection bags were to be kept off the floor.</p>	F 441	<p>Performance Improvement Committee meetings for three months. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.</p>	9/15/12	